Determining Special Education Eligibility - Autism

Department of Education, Office Special Education

Introduction

This category of eligibility has been defined by both federal and state regulations. A three-part eligibility requirement for a child to be identified as a child with autism is as follows:

- Meet educational identification criteria (92 NAC 51.006);
- Documentation of adverse effect on educational performance;
- A determination that a need for special education is evident.

State Definition

To qualify for special education services in the category of autism the child must have a developmental disability that significantly affects verbal and nonverbal communication and social interaction, is generally evident before age three, and that adversely affects a child's educational performance. Other characteristics often associated with autism are engagement in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual response to sensory experiences.

> Autism does not apply if a child's educational performance is adversely affected primarily because the child has a behavioral disorder as defined in 92 NAC 51-006.04C
>
> A child who manifests the characteristics of autism after age three could be identified as having autism if the other criteria in 92 NAC 51-006.04B1 are met.

Guiding Definition

In order to provide a broad base of understanding of autism and the continuum of behavioral characteristics of children with **Autism Spectrum Disorders (ASD)**, the term **Autism** will be used throughout this technical assistance guide.

Autism spectrum disorder (ASD) refers to a behaviorally defined neurodevelopmental disability characterized by qualitative impairments of social reciprocity, nonverbal and verbal communication, and flexibility in thoughts and actions. In recent years ASD has been described as a "disconnectedness syndrome" (Geschwind & Levitt, 2007). It is considered to be a biologically based condition involving differences in how parts of the brain and nervous system interact and develop over time. Although biological in nature, the exact causes are not yet known.

There is no medical test for ASD, and the only available way to determine if a child has an ASD is to look for a certain pattern of gaps or unevenness in the development of

social interaction, communication, and restricted patterns of activities and interests relative to the child's overall developmental level.

Autism is often referred to as a "Spectrum Disorder". This means that people with autism will be affected in different ways ranging from very mild to severe. Individuals with autism share some similar symptoms and characteristics such as difficulty with social interactions. There are however differences in when symptoms start, how severe they are and the exact nature of the symptoms. (CDC, 2014)

Autism exists on a continuum from mild to severe. Learning, responding, and thinking differences result in confusion, frustration, and anxiety expressed in withdrawal, repetitive behaviors, and, sometimes, in aggression or self-injury. Autism can co-occur with other disabilities.

ASD begins in early childhood and lasts throughout a person's life, although symptoms may improve over time. Some children with ASD show indicators of future problems within the first few months of life. In other individuals, the characteristics of autism might not show up until 24 months or later. Another group of individuals with autism seem to develop typically until around 18 to 24 months of age and then they stop gaining new skills, or they lose the skills they once had (Centers for Disease Control, March 2012).

ASDs are behaviorally defined and commonly identified by the evidence of behavioral characteristics across multiple areas of functioning. Characteristics are observed, to varying degrees, in social relationships, communicative competence and pattern and range of interests. Although ASDs are defined by a certain set of behaviors, children may exhibit any combination of the behaviors in any degree of severity. These characteristics are generally evident during the child's early years, and must adversely affect educational performance.

Autism is one of the disability categories in which a student may receive special education services. An educational identification of autism refers to a process that is completed by a multidisciplinary team to identify if the student is eligible for special education services.

The term Autism Spectrum Disorder is used by Psychologists, Psychiatrists and/or Physicians when giving a Clinical or Medical Diagnosis of ASD. The Diagnostic and Statistical Manual of Mental Disorders (5th) Edition, American Psychiatric Association (DSM-5) is used to determine a medical diagnosis of autism spectrum disorder. A medical diagnosis is not required in order for an individual to receive an educational identification under the Autism disability category. However, medical reports and information should be considered by the MDT.

Table 1: Differences Between Educational Identification and Clinical Diagnosis Of ASD

	EDUCATIONAL IDENTIFICATION	CLINICAL DIAGNOSIS
Source for definition of ASD in Nebraska	NAC 51.006	DSM-5 (APA, 2013)
Decider: (i.e., who chooses the Special education disability category?)	The Multidisciplinary Team (MDT) or Individual Education Program (IEP) Team (which includes families, educational professionals and sometimes the student)	Psychologist, Psychiatrist or Physician
Time frame that applies	Evident & impairing right now, will be re-evaluation at least every 3 years	Lifelong, persistent condition, assumed to have been present in the past and assumed to be present in the future

Information included In the assessment or evaluation	• Academic achievement across several areas • Observation of behaviors in structured and unstructured school situations • Direct observation of social and communicative behaviors • Family interview for developmental and family history • Assessment of ASD characteristics • Teacher/Family report of problem behaviors and adaptive skills • May include: ○ standardized assessments of intellectual functioning, language, motor skills, learning style, adaptive behaviors ○ existing educational record and medical/clinical reports, as provided by family	• Medical, family and developmental history • Caregiver reports of current functioning across settings • Direct observation of social and communicative behaviors • Further investigation into attention, mood or other aspects of mental health, as needed • Standardized assessments of overall intellectual functioning, speech & language, motor, and/or adaptive behaviors • May include: ○ physical exam, genetics testing, ○ neurological exam, or other relevant medical follow-up ○ existing educational record and medical/clinical ○ reports, as provided by family
Cost to the family	The evaluation process is part of a free and appropriate public education	Estimated cost of $1,500 - $3,500 (sometimes covered by insurance, sometimes not)

Access to experienced professionals	Child Find and Multidisciplinary team members are always available (i.e., part of a free and appropriate public education); NDE through the ASD Network provides training and guidance to school districts on the educational evaluation for ASD.	Geographically dependent: Qualified/trained diagnosticians often practice in metropolitan areas and rural/frontier counties may not have any medical or mental health professionals with experience in clinical diagnosis of ASD.
Functional Disability	The disability must affect educational performance (such as; academics, ability to communicate effectively, work in groups and acquire the necessary social competence to be successful after high school).	The condition may or may not be impairing to be clinically diagnosed.
Results are intended for:	Determine eligibility for special education services. If eligible, the team develops the student's Individualized Education Program, (including identifying appropriate educational goals and objectives, accommodations, modifications, and determination of the least restrictive environment) in order to provide the student with a free and appropriate education.	Guiding parents to appropriate next steps in intervention (both in and outside of school) in order to promote overall wellness and optimal outcomes for youth with ASD and their families.

Section 1: MDT Team Composition

The Multidisciplinary Team (MDT) should include at least the following members:

- The child's parent(s);
- A school psychologist or licensed psychologist;
- The child's teacher(s) or a teacher qualified to teach a child that age;
- A speech-language pathologist;
- A school district administrator or designated representative.

Section 2: Educational Identification Guidelines

In order for a child to have an educational identification of Autism, the evaluation should include the analysis and documentation of the manifestation of developmental and educational problems exhibited in varying degrees of impairments in each of the following areas:

There are three core areas of development that are central to an ASD:

1. **Impairments in Social Reciprocity** (i.e., the spontaneous ability to engage in back-and-forth social interactions with a variety of people in a variety of situations is awkward or missing). Some children with ASD may appear as "aloof" or "in their own world." They may persist in avoiding social contact with unfamiliar people in a manner that cannot be explained by shyness or fear. Others may seem socially interested, but have a very passive style, appearing to not know how to start or maintain interactions with others.

   Alternately, some children appear socially active and engaged in the flow of interactions, but their social style is experienced by others as "one-sided," "awkward," or "intrusive." For many children with ASD, interacting with adults (particularly familiar and/or responsive adults) is much easier than playing with their peers. For many individuals it isn't until school entry when his/her social challenges become apparent.

2. **Lack of Communicative Competence** (i.e., the child lacks the ability to send and receive messages to others in a fluid and integrated manner). This core category includes delayed or disordered speech, integration of nonverbal

behaviors into attempts to communicate (such as using a coordinated eye gaze, pairing gestures with sounds, using an appropriate voice tone and maintaining an appropriate proximity to others when communicating), as well as communicating for a range of social purposes (such as maintaining a conversation, asking for assistance, sharing observations and information).

For some highly verbal children with ASD, speech develops typically, however, learning how to communicate with others in a socially appropriate way can be challenging. This aspect of communication is referred to as pragmatics and is considered an educationally relevant aspect of adaptive behavior.

3. Restricted, Repetitive Patterns of Behavior, Interests or Activities (i.e., the child may demonstrate a strong preference for familiarity, routines, and an insistence on sameness in activities and behaviors). This core category can be evident through repetitive motor behaviors (such as hand-flapping or jumping and pacing), repetitive play with objects (such as lining up toys but not really playing "with" them). There may also be a "driven" desire for specific routines and/or rules to be followed, or an intense preoccupation with one interest, toy or part of an object, without really seeing the "big picture." "Getting stuck" or "perseverating" also describes this core category.

In addition, the following indicators may be observed in children with Autism:

Unusual or repetitive responses to sensory stimuli. The child may exhibit these atypical responses to any or all of the following sensory modalities: sight, hearing, smell, taste, touch, balance, body awareness, and pain. The intensity of the response to these stimuli can range from unusually high levels to unusually low levels.

- Differences in the rate of cognitive skill development
- Uneven rate or out-of-sequence skill development
- Extreme or deregulated behavioral characteristics – hyperactivity, short attention span, impulsiveness, emotional outbursts, verbal/physical aggressiveness, or self-injurious behaviors
- Difficulties with judgment, as evidenced by apparent lack of danger or potential harm; or excessive and unwarranted fearfulness
- Difficulties with abstract thinking

Other features of ASD that are present across the school years are:

- Rigidity in thinking, difficulty shifting from a thought, idea or expectation
- Over-selective attention focusing on detail but may not see the overall concept
- Socially naive, does not understand the intentions of others

Section 3: Educational evaluation should include a combination of the following methods and tools

Note: During the comprehensive evaluation no one assessment method alone is sufficient to determine eligibility for autism spectrum disorder. The multidisciplinary team will gather information through a variety of assessments, observation and data collection. Which assessments and the amount of information collected will be determined on a case-by-case basis.

- Behavioral observations take place in natural settings by a person or persons with child development experience and knowledge of ASD.

- Family/caregiver report of child's developmental history (e.g., first words/phrases, first steps), medical history and current strengths and difficulties, establishing that concerns were present before the third birthday, with the exception of a very high functioning child (no language delay) (See example Developmental History Questionnaire).

- A screening tool specific to ASD may be completed by family, teacher or both.

- Teacher input with a focus on a child's social, communication and/or play skills in natural activities and routines, and need for structure and modification to encourage child participation in learning.

- Review of existing educational records and reports regarding the child's achievement, behavior, participation in educational opportunities, with a look at whether or not social-communication difficulties accompanied by behavioral inflexibility are impacting the child's educational performance.

- Direct interaction with the child in either a play-based or semi-structured interaction with opportunities to probe the child's social-emotional understanding and observe the child's coordination of verbal and nonverbal communicative behaviors (e.g., does he easily coordinate his eyes, facial expressions, and/or gestures with his verbal communication?).

- Reports by outside sources including the diagnostic report, if available, will be considered.

- Standardized assessment of cognitive functioning, adaptive skills, executive function, speech/language/communication, academic achievement, sensory profiles and motor foundation/motor planning may add valuable information but must be determined on a case-by-case situation.

- If needed, to gather additional information, administration of an assessment tool specific to autism, such as the Autism Diagnostic Observation Schedule, 2nd edition or the Autism Diagnostic Interview, or both. Neither tool is required.

Section 4: PROCEDURES TO DETERMINE ADVERSE EFFECT ON DEVELOPMENT/EDUCATIONAL PERFORMANCE

FACTORS TO CONSIDER

In observing, assessing, and evaluating the child's behavioral characteristics, the following questions are to guide documentation and determination of whether the disability has an adverse effect on the child's developmental/educational performance:

Impairments in Social Competence

Does the child appropriately use nonverbal communication and gestures; exhibit a smiling response; exhibit stranger anxiety; exhibit response to gestures and familiar routines; exhibit eye contact and facial responsiveness?

Does the child follow a point or use a forefinger point with the intent of directing the attention of a peer or adult toward the object?

Does the child show awareness of the essential components of social interactions, i.e., nonverbal and verbal communication, empathy, reciprocity, social negotiation and repair?

Does the young child demonstrate reciprocal routines or social games such as peek-a-boo, patty-cake, or waving good-bye?

Does the young child demonstrate age appropriate play skills including using objects for intended purpose, pretending, and/or imitating (other than scenarios from movies and cartoons)?

Does the child demonstrate cooperative play in response to social cues and/or direct instruction?

Does the child prefer to be alone and/or show little interest in others?

Does the child fail to develop relationships with significant caregivers
Does the child have difficulty relating to others?

Does the child attempt social interactions that are ineffective, inappropriate, and thus unsuccessful?

Does the child exhibit giggling, laughing, or crying without identifiable reasons?

Lack of Communicative Competence

Is the child's speech echolalic?

Does the child have difficulty using language in fluent, interactive communication?

Does the child use nonverbal language, i.e., gestures, gestures that relate to language, and symbolic meaning of gestures?

Is the child's use of language concrete and literal; does the child seem to be confused by words and expressions that depend on the context for meaning, such as space and time words, i.e., here/there/later; homonyms, i.e., blue/blew; pronouns, jokes, sarcasm, and figurative language?

Does the child display loss of speech, delayed onset of speech, immature or disordered syntax, and/or articulation?

Does the child use formal or stilted speech to communicate, i.e. addressing others formally, including people they know well, or using higher level awkward vocabulary instead of more comfortable slang or language children usually display?

Is the child's voice quality flat or mechanical with little variation of pitch and volume?

Does the child have difficulty using language in fluent, interactive communication?

Restricted, Repetitive Patterns of Behavior, Interests or Activities

Does the child use objects in idiosyncratic, stereotypic, and/or perseverative ways, and does interference with this use of objects result in expressions of discomfort and/or panic?

Does the child exhibit awareness of the sequence of events and exhibit discomfort and/or panic when this sequence is disrupted or changed?

Does the child have complex routines or rituals for particular activities and does the child exhibit distress if he/she is unable to carry out these routines, i.e., lining up objects, needing to have his/her desk in the same position, following rigid routines (bed time, mealtime, getting dressed, reading a book)?

Does the child engage in self-injurious behaviors, i.e., hair pulling, head banging, or hitting/biting parts of the body?

Does the child exhibit stereotypic and repetitive movements of limbs or the entire body i.e., hand flapping, hand wringing, or spinning?

Does the child demonstrate perseverative thinking, preoccupation with certain sounds, words, phrases, ideas, or does the child have difficulty switching the focus of attention?

Does the child demonstrate a skill in a particular setting or situation or with a specific person, but have difficulty generalizing that skill to another setting, situation, or person?

Does the child show memory for specific visual detail, facts, or rote lists, but fail to demonstrate a general understanding of the topic?

Does the child focus on small details and demonstrate little awareness of critical elements or information?

Section 5: RELATED DEFINITIONS

Glossary of Commonly Used Terms and Acronyms: (adapted from the Autism Society of Georgia and the Autism Society of Oregon)

ABA – Applied Behavior Analysis – a professional field that uses principles of learning to increase performance of socially desirable behaviors. It always relies upon the collection of objective data to measure performance and the effectiveness of an intervention. ABA is used in industry, business and education as well as in the field of disabilities. The term "ABA" is sometimes used to refer to a one-on-one therapy that is named discrete trial training. Some educational professionals as well as parents will use the term ABA when referring to this type of one-on-one therapy. See Discrete Trial Training.

Adaptive Behavior – The ability to adjust to new situations and to apply familiar or new skills to those situations.

ADD – Attention Deficit Disorder; See also ADHD (Attention Deficit Hyperactivity Disorder)

ADHD – Attention Deficit Hyperactivity Disorder – A group of symptoms believed to be caused by slight abnormalities in the brain. These symptoms include a developmentally inappropriate lack of ability to attend (such as difficulty with listening to and following directions), impulsivity, distractibility, clumsiness and hyperactivity. ADHD occurs in as many as three percent of children, with onset prior to four years of age in about 50 percent of cases.

Annual Goal – A statement of the desired outcome of early intervention services or education for a specific child and his family. Annual goals for early intervention are selected by the child's parents and the child's early intervention multidisciplinary team. They are stated on the Individualized Family Service Plan (IFSP). Annual goals for education also are developed by a team that includes the child's parents, and are stated in the Individual Education Plan (IEP). Objectives may also be stated to provide developmentally appropriate activities and measurement of progress toward attainment of the goal. Objectives are more specific and measurable.

Apraxia – The loss of ability to perform voluntary movements (i.e., the brain is unable to translate thoughts about moving into actual movement).

AS -Asperger's Syndrome – Condition found in the DSM-V manual under Autism Spectrum Disorders. The essential features are severe and sustained impairment in social interaction and the development of restricted, repetitive patterns of behavior, interests and activities. Additional criteria are listed in the DSM-V.

AT – Assistive Technology – Special items or equipment used to increase, maintain, or improve one's functioning abilities. The term covers items such as computers, pencil holders, specialized switches and calculators.

Audiologist – A specialist who determines the presence and type of hearing impairment.

Audiology – The study of hearing and hearing disorders.

AAC – Augmentative & Alternative Communication – Any method of communicating without speech, such as by signs, gestures, picture boards, or electronic or non-electronic devices. These methods can help individuals who are unable to use speech or who need to supplement their speech to communicate effectively.

BIP – Behavior Intervention Plan – A written document that becomes part of the IEP and which identifies problem behaviors; sets goals for decreasing unwanted behaviors and increasing desired behaviors; and outlines interventions to use when specific behaviors occur. Sometimes call a behavior management plan.

Behavior Modification – A method of manipulating behavior through the use of rewards and consequences.

Behavioral Assessment – Gathering (through direct observation and by parent report) and analyzing information about a child's behaviors. The information may be used to help the child change unwanted behaviors. Variables that are noted include when a behavior occurs as well as its frequency and duration. See Functional Behavior Assessment.

Behavioralist – A person who observes behavior and then helps the person develop more adaptive alternative behaviors.

CARS – Childhood Autism Rating Scale, a screening tool for autism.

CHAT – Checklist for Autism in Toddlers, a screening tool for autism in young children.

Cognitive – Referring to the developmental area that involves thinking skills, including the ability to receive, process, analyze and understand information.

Communication – The developmental area that involves skills which enable people to understand (receptive language) and share (expressive language) thoughts and feelings.

Communication Aid – A nonverbal form of communication such as gesture, sign language, communication boards and electronic devices.

Communication Board/Book – A board or book with pictures or symbols that a child or adult can point to for expression of his or her needs.

Communication Disorder – Difficulty with understanding and/or expressing messages. Communication disorders include problems with articulation, voice disorders, stuttering, language disorders and some learning disabilities.

Community Based Instruction – Refers to instruction which occurs in the community instead of on the school campus. Recreation/leisure, vocational, community, and domestic activities may take place in community settings. The advantage of this instruction is that the student learns skills in the natural context in which they are to be used.

Consequence – Something that occurs as the direct result of action or effort. Consequences can be pleasant and reinforcing or unpleasant and punishing. Some consequences occur naturally, (i.e., when you touch a hot stove, you get burned).

DD Services – Developmental Disability Services. Governmental services for children and adults accessed through each county in Oregon. A department under DHS.

Developmental Delay – The term used to describe the condition of an infant or young child who is not achieving new skills in the typical time frame and/or is exhibiting behaviors that are not appropriate for his or her age. Some children who are developmentally delayed eventually have a specific diagnosis of a particular developmental disability. Other children with delays catch up with their typically developing peers.

DD – Developmental Disability – Any physical or mental condition (such as mental retardation, cerebral palsy, epilepsy, autism or a neurological disorder) that has the following characteristics: (1) begins before the age of 22 years, (2) causes the child to acquire skills at a slower rate than peers, (3) is expected to continue indefinitely and (4)

impairs the child's ability to function normally in society. (This description is based on the federal definition of developmental disability, which is used to determine who receives particular services through federal funds.)

DSM-V – Diagnostic and Statistical Manual of Mental Disorders – The fifth edition of the reference manual published by the American Psychiatric Association, for which the text was revised in 2014. The DSM-V appears to be the most widely used manual of diagnostic criteria for autism spectrum disorders in the United States.

DTT – Discrete Trial Training – A method for teaching desired behaviors, skills or tasks. The skill being taught is "broken" down or sequenced into small, "discrete steps" that are taught in a highly structured and hierarchical manner. The therapist or caregiver systematically rewards or reinforces desired responses and ignores, redirects or discourages inappropriate responses. Data on all learning is recorded regularly and the therapist adjusts the teaching program as needed.

EI/ECSE – Early Intervention/Early Childhood Special Education – Individualized services for infants and toddlers to age 5 who are at risk for or are showing signs of developmental delay.

Echolalia – The repetition of speech that is produced by others (a relatively common symptom of autism). Echoed words or phrases can include the same words and inflections as were originally heard or they may be somewhat modified. Immediate echolalia refers to works immediately repeated or repeated a brief time after they were heard. Delayed echolalia refers to the repetition of speech much later – even after days or years.

ESY – **Extended School Year** – Special education and related services provided beyond the normal school year, in accordance with the child's IEP and at no cost to the parents.

Expressive Language – Refers to the language that the individual can communicate to others. Generally, when referring to oral expressive language, it indicates the individual' ability to express thoughts, feelings, wants, and desires through oral speech. Expressive language may also refer to gestures, signing, communicating through pictures and objects, and writing. Compare to Receptive Language.

FAPE – Free Appropriate Public Education, what every student is entitled to under the Individuals with Disabilities Education Act (IDEA). **See IDEA.**

Fine Motor Skills – The developmental area involving skills that require the coordination of the small muscles of the body, including those of the hands and face.

FBA – Functional Behavior Assessment – The process of systematically determining the function of behaviors, usually inappropriate, that are displayed by people. Behaviors are defined, measured and analyzed in terms of what happened before and after their occurrence. Based on information gathered a judgment is made about the possible communicative function of the behavior(s). Functional assessments are usually performed in order to develop behavior interventions and supports that address challenging or inappropriate behaviors. See Behavioral Assessment.

Generalization – The ability to take a skill learned in one setting, such as the classroom, and use it in another setting like the home or community.

Gross Motor Skills – The developmental area involving skills that require the coordination of the large muscles of the body, including the legs.

HFA – High Functioning Autism

Hyperlexia/Hyperlexia – Ability to read at an early age, but often without linking the words to what they mean

Hyperactivity – Abnormally increased motor activity, resulting in difficulty with concentrating on one task or sitting still. Due to their overactivity and impulsivity, children who are hyperactive often have difficulty with learning, even if they score in the normal range on IQ tests. Hyperactivity can occur with attention deficit disorder, mental retardation, seizure disorder, sensory deficit disorders or other central nervous system damage. Also known as hyperkinetic.

Hypersensitivity – Oversensitivity to sensory input (often to the point of pain).

Hyposensitivity – Under-sensitivity to sensory input, resulting in little or no response to noise, hot/cold, etc.

IDEA – **Individuals with Disabilities Education Act** – A federal law passed in 1997 that reauthorized and amend the Education for All Handicapped Children Act (Public Law 94-142). Provides special education services for children with 1 of 11 categories of disability so they can access a Free and Appropriate Public Education (FAPE).

IEP – Individualized Education Plan – A written statement of a child's current level of development (abilities and impairments) and an individualized plan of instruction,

including the goals, the specific services to be received, the people who will carry out the services, the standards and time lines for evaluating progress, and the amount and degree to which a child will participate with non-handicapped peers at school. The IEP is developed by the child's parents and professionals who evaluated the child. It is required by the Individuals with Disabilities Education Act (IDEA) for all children in special education, ages three years and up.

IFSP – **Individualized Family Service Plan** – A written plan describing the child ages 0-5's current level of development; the family's strengths and needs related to enhancement of the child's development; goals for the child and the other family members (as applicable), including the criteria, procedures and time lines used to evaluate progress, and the specific early intervention services needed to meet the goals, including the frequency and intensity and method of delivering services, the projected date of initiating services and the anticipated duration of services. The IFSP is developed and implemented by the child's parents and a multidisciplinary Early Intervention team. The IFSP should be evaluated and adjusted at least once a year and reviewed at least every six months. The IFSP is required by the IDEA for all children receiving early intervention services. Refer to **Early Intervention** and **Individuals with Disabilities Education Act**.

Inclusion – The general concept of including people with disabilities in all aspects of life, such as (but not limited to) education, community living, employment and recreation.

Joint Attention – Coordinating attention about an object of mutual interest. This involves shifting attention from each other to an object and back. Joint attention is sometimes called referential looking.l

LRE – Least Restrictive Environment – The educational setting that permits a child with disabilities to derive the most educational benefit while participating in a regular educational environment to the maximum extent appropriate. LRE is a requirement under the IDEA.

Modifications – Alterations of the curriculum, the support systems, the environments, or the teaching strategies to match individual needs to ensure that the student can participate actively and as independently as possible.

Motor Planning – The ability of the brain to conceive of, organize, and carry out a sequence of unfamiliar actions. Also known as praxis.

Motor Skill – The learned ability to perform movements, such as holding the body in an upright position to sit, using the hands to manipulate small items, scooping food onto a spoon and bringing the spoon to the mouth, and moving the lips and tongue to articulate different sounds.

Multidisciplinary Team – Refers to an assessment team which has professional members from various disciplines (education, speech pathology, psychology, medicine, etc.) to evaluate the "total child".

Nonverbal Communication – Any form of or attempt at unspoken or "physical" communication. Examples are temper tantrums, gestures, pointing and leading another person to a desired object.

NT – Neurologically typical/neuro-typical.

OCD – Obsessive Compulsive Disorder

ODD – Oppositional-Defiant Disorder

OHI – Other Health Impairment, one of the 11 qualifying disabilities for IDEA

Oral Motor – Relating to the muscles of the mouth.

OT – Occupational Therapy – Therapeutic treatment aimed at helping the injured, ill or disabled individual to develop and improve self-help skills and adaptive behavior and play. The occupational therapist also addresses the young child's motor, sensory and postural development with the overall goals of preventing or minimizing the impact of impairment and developmental delay. The therapist also promotes acquisition of new skills to increase the child or adult's ability to function independently.

PECS – **Picture Exchange Communication System (PECS)** – An alternative communication system that uses picture cards.

Perseveration – Repetitive movement or speech, or sticking to one idea or task

PT -Physical Therapy – Therapeutic treatment designed to prevent or alleviate movement dysfunction through a program tailored to the individual child. The goal of the program may be to develop muscle strength, range of motion, coordination or endurance; to alleviate pain; or to attain new motor skills. Therapeutic exercise may include passive exercise (in which the therapist moves and stretches the child's

muscles) or the child may actively participate in learning new ways to acquire and control positions and movement.

Pragmatics – The understanding of how and why language is used – especially in social situations.

PreK – PreKindergarten

Prompt – Input that encourages an individual to perform a movement or activity. A prompt may be verbal, gestural or physical. Also known as a "cue".

Proprioception –The body's conscious or unconscious awareness of its position in relation to its surrounding.

Receptive Language – The ability to understand what is being expressed, including verbal and nonverbal communication. Compare to Expressive Language.

Regression – Reverting to a more immature form of behavior or decreased skill level.

Reinforcement – A pleasant event that occurs immediately as a direct result of an action and that increases the strength of the action or the likelihood that the action will be repeated.

Related Services – Additional services at school that would help a child further benefit from his special education. These services might include speech, occupational therapy,transportation, etc.

Respite/Respite Care – Skilled, adult supervision of a person with special needs with the goal of

Self-Contained – In reference to special education, refers to schools or classrooms containing only special needs population.

Self-Stimming, Self-Regulatory and Self-Stimulatory Behavior – Defined as unusual behaviors that interfere with the individual's ability to pay attention or participate in meaningful activity, such as head banging, watching fingers wiggle or rocking side to side. Unpurposeful play with a toy can be self-stimulating, such as repetitively spinning the wheels of a toy truck instead of exploring the different ways it can be used. In children, self-stimulation is most common when there is a diagnosis of mental retardation, autism or a psychosis.

Sensory Diet – An activity plan that includes specific activities designed to decrease sensory defensiveness. Timing, intensity, and sensory qualities of these activities are highlighted.

Sensory Impairment – A problem with receiving information through one or more of the senses (sight, hearing, touch, etc.).

Sensory Integration – The ability of the central nervous system to receive, process, and learn from sensations in order to develop skills. The sensations include touch, movement, sight, sound, smell and the pull of gravity.

SLP – Speech-Language Pathologist

Social Skills – Positive, appropriate, social behaviors that are generally considered necessary to communicate and interact with others.

Speech Therapy – Therapy to improve the individual's speech and language skills, as well as oral motor abilities.

Tactile – Relating to the sense of touch.

Task Analysis – Process of breaking a skill down into smaller steps.

TEACCH – **T**reatment and **E**ducation of **A**utistic and related **C**ommunication handicapped **CH**ildren – A structured teaching intervention developed by Division TEACCH of the University of North Carolina at Chapel Hill. The components of the program include physical structure, schedules, individual work systems, visual structure, and routines.

Transitions – May refer to changes from one environment to another such as from an early childhood program to a kindergarten or first grade class or from a secondary program to the world of work. Transitions may also refer to changes from one activity to another. Transitions are typically very difficult for individuals with autism.

Vestibular – Sensory system located in the inner ear that allows the body to maintain balance.

Visual Supports/Visual Adaptations – Written schedules, lists, charts, picture sequence, and other visuals that convey meaningful information in a permanent format for later reference. Visual supports allow the person with autism to function more independently without constant verbal directions.

Section 6: FREQUENTLY ASKED QUESTIONS

1. What is the difference between a medical diagnosis and an educational identification?

A medical diagnosis is usually given by a doctor or clinical psychologist. The diagnosis is established to guide medical treatment and decision-making, not to address educational needs.

An educational verification is a process conducted by a school district to determine if a child has a disability and to plan appropriate services to address the child's individual needs. The verification will reflect assessments done by a multidisciplinary team. Verification is based on an educational model.

2. Is a medical diagnosis required in order for a child to be Identified educationally as a child with Autism?

No. While many states do require documentation of a medical diagnosis, Nebraska does not. A child may have an educational identification of Autism irrespective of any medical diagnosis.

3. At what age should a child suspected of having Autism be evaluated?

At any age. Research shows that early intervention has a significant impact in development for children with Autism. If there are concerns that a child is not developing appropriate social and communication skills, those concerns should be discussed with professionals for consideration of a referral to the MDT team.

4. Can a child with an Autism disability also have other disabilities?

Yes. It is possible for a child with Autism to receive and educational identification of autism and also be diagnosed with other disabilities.

5. Should the multidisciplinary (MDT) request and consider medical information from the child's physician as part of the assessment?

Yes. Collecting information from a variety of sources can be beneficial in the verification process. If the MDT agrees that medical information will be helpful, this information may be requested. Parents, who are part of the MDT, should sign a release of information and/or provide this information themselves.

6. If assistance is needed with educational identification and/or program planning for a child suspected of having Autism, where can the school find help?

The Nebraska Autism Spectrum Disorder (ASD) Network is funded through the Nebraska Department of Education to provide training and technical assistance to school teams with verification and educational program planning. There are also resource libraries across the state where books, videos, and other materials related to ASDs may be checked out. Visit the ASD Network web site (www.nde.state.ne.us/autism) to find information on how to contact the regional coordinator.

7. Do we know the cause of autism?

No, at this time, there is no known cause for autism spectrum disorder.

Researchers are investigating a number of theories and most believe there will not be one single cause but a number of pathways to an ASD including genetics, heredity, environment and medical problems. Currently, no single gene or gene segments or environmental factors have been identified. Literature on brain scan research has shown that there are "structural and functional abnormalities of the brain. They are seen as cognitive and neurological abnormalities that are ultimately manifested as behavioral differences" (Minshew & Williams, 2007). While individuals with ASD can improve markedly over time, there is no known cure for this set of conditions. Early intervention can improve both developmental functioning and the quality of life for the individual and his or her family (Eikeset, Smith, Jahr, & Eldevik 2007; Howlin, 2008; Rogers & Vismara, 2008). The most effective interventions at the present time are educational, behavioral, and communicative.

8. What is the prevalence of autism and why is it increasing?

There has been a steady increase in the incidence rate for ASD since the mid-1990s. The Centers for Disease Control and Prevention (CDC) reported that **1 in 54** young children have autism spectrum disorder (CDC, 2016). There are several factors that are involved in the reported increase including (a) expanding the definition from autism to autism spectrum disorder, (b) increasing knowledge of the disorder by professionals which leads to an increase in diagnosing,(c) more consistency by CDC's Autism and Developmental Disabilities Monitoring (ADDM) Network in the method used to count and (d) an actual increase in the rate of children being born with the disorder.

Most individuals with ASD face one or more additional challenges, including learning disabilities, psychiatric conditions, difficulties with sleeping, eating,

regulating behaviors, and attending to an activity or conversation in an appropriate way. Researchers are also investigating co- occurring medical conditions, which have been observed in some individuals with this complex condition, such as immune system irregularities, endocrine disorders, neurological conditions (such as seizures), and gastrointestinal disorders (Coury, 2010).

SECTION 7: RESOURCES AND REFERENCES

The following documents are examples for your information only. They may aid in the evaluation but are not required.

Red Flags at Different Ages Resource

Developmental History Questionnaire

School Observation Guide

Summary of Results Form

WEBSITES

- The Nebraska ASD Network:https://www.unl.edu/asdnetwork/home
- American Academy of Pediatrics: http://www.aap.org/en-us/Pages/Default.aspx
- Association of University Centers for Disabilities: (AUCD). which serves as a hub for technical assistance, service, treatment and research in developmental disabilities. http://www.aucd.org
- Autism Speaks http://www.autismspeaks.org
- Autism Society of America http://www.autism-society.org/
- Centers for Disease Control Autism Awareness Campaign: "Learn the Signs. Act Early": http://www.cdc.gov/actearly 1-800-CDC-INFO
- For video clips of children with and without ASD at different ages and developmental levels, see: http://www.firstsigns.org/asd_video_glossary/asdvg_about.htm
- For handouts for parents and colleagues about autism (fact sheets, developmental milestones, etc.), see: http://www.cdc.gov/ncbddd/autism/freematerials.html
- For the part of IDEA that describes the legal requirements for an evaluation for educational eligibility: http://idea.ed.gov/explore/view/p/%2Croot%2Cregs%2C300%2CD%2C300%252E304%2C
- For a list of eligibility categories and their definitions: http://idea.ed.gov/explore/view/p/%2Croot%2Cregs%2C300%2CA%2C300%252E8%2C

- For an assessment toolkit development by the Office of Special Education Programs (OSEP): http://osepideasthatwork.org/toolkit/tk_descision.asp

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Appendix A - Developmental History Questionnaire

Child's Name: _____ Today's Date: _____

Date of Birth: _____ Age _____

School: _____ Grade: _____

Parents/Guardian
Name(s):_____

Person completing questionnaire: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Dear Parent or Guardian:

This questionnaire has been developed to help us better understand your child's background, special health needs, and developmental progress.

- You have the right to leave any question blank.
- This information shall be considered confidential and shall not be forwarded outside the school district without the written consent of the parent or guardian.
- We will use this information in addition to other assessment material in planning educational programming or services for your child.

If you have any questions please contact one of the following individuals:

Child Find Coordinator _____ Phone #_____ Email_____
Ages 0-3

Case Manager _____ Phone #_____ Email_____
Ages 3-21

I. FAMILY HISTORY

Father/Step-Father/Guardian's Name:

_____

Occupation:

_____

Home phone: _____ Work Phone: _____ Cell Phone: _____

Mother/Step-Mother/Guardian's Name:_____

Occupation:_____

Home phone: _____ Work Phone: _____ Cell Phone: _____

If applicable, Guardian's Name: _____

Home phone: _____ Work Phone: _____ Cell Phone: _____

Language(s) spoken in the home:_____

Child's primary language: _____

Current family status:

____Married ____Separated ____Divorced ____Widowed ____Never Married ____Blended family

Please list all People in child's immediate home and their relationship to child:

_____

Does child have any siblings? __Yes __ No How many?_____

Ages:_____

Child resides with (please include all adults living in the home):_____

Any concerns about the development of siblings?

_____

Has any biological family member had any of the following?	Please list the biological family member's relationship to the child.
Learning Disabilities	
Speech or Language Problems	
Tourette's Syndrome	
Attention Deficit Disorder	
Emotional Problems (anxiety, depression, etc.)	
Developmental Disorder (Autism Spectrum Disorder, Asperger Syndrome, etc.)	
Tourette's Syndrome	
Diabetes	
Developmental Delay of Cognitive Disability	

Does anyone else care for your child on a regular basis? ___Yes ___No
If yes, please describe the care giving arrangements (i.e.: private daycare, family, public daycare center):_____
_____

II. PREGNNCY AND BIRTH HISTORY
Describe any difficulties during pregnancy (i.e. high blood pressure, toxemia, diabetes and/or premature contractions):
_____
List any prescribed and/or over the counter drugs used during pregnancy:
_____

Did you smoke during pregnancy? ____Yes ____No
Did you use alcohol during pregnancy? ____Yes ____No
Were there any unusual or stressful situations during your pregnancy (divorce, death, illness, accident) ____ Yes ____ No If yes, please describe:
_____

Length of pregnancy (weeks):_____ Infant birth weight:_____

Were there any complications during labor and/or delivery (i.e.: difficulty breathing, cord wrapped around the neck)? ____Yes ____No If yes, please explain:
_____

Did your newborn require any specialized treatments (i.e., oxygen, IV medication)?
_____
_____

III. INFANT/TODDLER DEVELOPMENT
Rolled over by what age? _____
Sit alone by what age? _____
Crawl by what age? _____
Walk alone by what age? _____
Babbled by what age? _____
Said “mama” “dada” with meaning by what age? _____
Said other single words by what age? _____
Put two words together by what age? _____
Used longer phrases and sentences by what age? _____
Were there any losses of skills at any time? ____Yes ____No If yes, please describe:_____

Did your child experience any health problems during infancy? If so what type?
_____

Describe your current concerns about your child’s development:
_____
_____
_____

HEALTH HISTORY

Date of last physical exam:_____

Parent and/or physician's concerns:_____

_____

Has your child had any of the following? Check all that apply.	Describe the condition and the age of onset.
Frequent ear infections	
Seizures	
Hearing Loss/hearing aids	
Vision Problems	
Head Injury	
Neglect/Abuse	
Allergies	
Sleeping Problems	
Limited diet/food sensitivities	

Has your child been diagnosed by a health professional with any disability? If yes, please describe and list diagnosing doctor:

_____

_____

Is your child currently taking any medications? ____ Yes ____ No

If yes, please list:_____

Does your child require any special medical care or procedures at home or school? ____ Yes ____ No

If yes, please explain (i.e.: G-Tube, nebulizer treatment, catheterization, tracheostomy care, oxygen, Epi-pen)

_____

_____

SOCIAL AND PLAY SURVEY			
	RARELY	SOMETIMES	FREQUENTLY
At home my child usually follows our rules and requests.			
My child enjoys physical activity such as swinging, climbing, jumping and hanging upside-down.			
My child can play independently for short periods of time.			
My child avoids messy activities such as play-dough and finger-paints.			
My child is overly alert or disturbed by minor noise and/or movement.			
My child has difficulty with hitting, kicking, or biting other children.			
My child can play cooperatively alongside other children for short periods of time.			
My child usually maintains eye contact when speaking to a familiar person.			
My child is beginning to understand sharing and turn-taking.			
My child is appropriately cautious with strangers.			
My child does not usually scream, cry, or tantrum for longer than ten minutes at a time.			
My child will sit and look at books independently.			
My child can follow simple directions (i.e.: “Go to your room and get your shoes”).			
My child points to objects (points to juice, points to a toy he/she wants).			
My child is beginning to use pretend play (cooking, going to work, talking on the phone, cleaning).			
My child has unusual interests			
My child transitions easily from one activity to another			
My child enjoys making family members laugh (makes silly faces or noises).			

What kind of games and activities (i.e.: books, dolls, blocks, art activities, balls, puzzles) does your child enjoy?

_____

_____

Any particular or unusual habits that you are concerned about (i.e.: aggression towards others, head banging, poor impulsive control, or harming themselves in anyway)? ___Yes ___No
If yes, please describe the areas of concern:

_____

_____

Does the child have any out of the ordinary fears? ___Yes ___No
If yes, please describe the type of fear:

_____
_____

Are there any traumatic or significant events in your child's history that you would like to share?

_____
_____

Has any other professional completed an evaluation on your child (pediatrician, speech and language evaluation)? ___Yes ___No

If yes, would you be willing to share their reports and/or findings with this evaluation team?
___Yes ___No

In the event further evaluation is recommended is there anyone else you would like to include or would like this staff to collaborate with such as grandparents, daycare providers, etc.: ___Yes ___No
If yes, please name: _____

List all past/current treatment intervention (speech-language, psychology, occupational therapy, physical therapy,
etc).____
_____
_____

Thank You! We look forward to working with your family.